Senate Bill No. 866

CHAPTER 648

An act to add Section 1367.241 to the Health and Safety Code, and to add Section 10123.191 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 9, 2011. Filed with Secretary of State October 9, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SB 866, Hernandez. Health care coverage: prescription drugs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Commonly referred to as utilization review, existing law governs the procedures that apply to every health care service plan and health insurer that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees or insureds, as specified.

Existing law also imposes various requirements and restrictions on health care service plans and health insurers, including, among other things, a prohibition on health care service plans and health insurers that provide prescription drug benefits from excluding or limiting coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which the drug has been approved for marketing by the federal Food and Drug Administration. Existing law also requires a health care service plan that provides prescription drug benefits to maintain an expeditious process by which prescribing providers, as described, may obtain authorization for a medically necessary nonformulary prescription drug, according to certain procedures.

This bill would require the Department of Managed Health Care and the Department of Insurance to, on or before July 1, 2012, develop a prior authorization form for use by every health care service plan and health insurer that provides prescription drug benefits, except as specified. On and after January 1, 2013, or 6 months after the form is developed, whichever is later, the bill would require every prescribing provider, as defined, when requesting prior authorization for prescription drug benefits, to submit the prior authorization form to the health care service plan or health insurer, and would require those plans and insurers to utilize and accept those prior authorization forms for prescription drug benefits. Except as specified, upon a failure by the plan or insurer to accept the prior authorization form or to

respond to a prescribing provider within 2 business days, the bill would deem the prior authorization request as granted.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.241 is added to the Health and Safety Code, to read:

1367.241. (a) Notwithstanding any other provision of law, on and after January 1, 2013, a health care service plan that provides prescription drug benefits shall accept only the prior authorization form developed pursuant to subdivision (c) when requiring prior authorization for prescription drug benefits. This section does not apply in the event that a physician or physician group has been delegated the financial risk for prescription drugs by a health care service plan and does not use a prior authorization process. This section does not apply to a health care service plan, or to its affiliated providers, if the health care service plan owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

(b) If a health care service plan fails to utilize or accept the prior authorization form, or fails to respond within two business days upon receipt of a completed prior authorization request from a prescribing provider, pursuant to the submission of the prior authorization form developed as described in subdivision (c), the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200) of the Welfare and Institutions Code.

(c) On or before July 1, 2012, the department and the Department of Insurance shall jointly develop a uniform prior authorization form. Notwithstanding any other provision of law, on and after January 1, 2013, or six months after the form is developed, whichever is later, every prescribing provider shall use that uniform prior authorization form to request prior authorization for coverage of prescription drug benefits and every health care service plan shall accept that form as sufficient to request prior authorization for prescription drug benefits.

(d) The prior authorization form developed pursuant to subdivision (c) shall meet the following criteria:

(1) The form shall not exceed two pages.

(2) The form shall be made electronically available by the department and the health care service plan.

(3) The completed form may also be electronically submitted from the prescribing provider to the health care service plan.

(4) The department and the Department of Insurance shall develop the form with input from interested parties from at least one public meeting.

(5) The department and the Department of Insurance, in development of the standardized form, shall take into consideration the following:

(A) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(B) National standards pertaining to electronic prior authorization.

(e) For purposes of this section, a "prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

SEC. 2. Section 10123.191 is added to the Insurance Code, to read:

10123.191. (a) Notwithstanding any other provision of law, on and after January 1, 2013, a health insurer that provides prescription drug benefits shall utilize and accept only the prior authorization form developed pursuant to subdivision (c) when requiring prior authorization for prescription drug benefits.

(b) If a health insurer fails to utilize or accept the prior authorization form, or fails to respond within two business days upon receipt of a completed prior authorization request from a prescribing provider, pursuant to the submission of the prior authorization form developed as described in subdivision (c), the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200) of the Welfare and Institutions Code.

(c) On or before July 1, 2012, the department and the Department of Managed Health Care shall jointly develop a uniform prior authorization form. Notwithstanding any other provision of law, on and after January 1, 2013, or six months after the form is developed, whichever is later, every prescribing provider shall use that uniform prior authorization form to request prior authorization for coverage of prescription drug benefits and that every health insurer shall accept that form as sufficient to request prior authorization for prescription drug benefits.

(d) The prior authorization form developed pursuant to subdivision (c) shall meet the following criteria:

(1) The form shall not exceed two pages.

(2) The form shall be made electronically available by the department and the health insurer.

(3) The completed form may also be electronically submitted from the prescribing provider to the health insurer.

(4) The department and the Department of Managed Health Care shall develop the form with input from interested parties from at least one public meeting.

(5) The department and the Department of Managed Health Care, in development of the standardized form, shall take into consideration the following:

(A) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(B) National standards pertaining to electronic prior authorization.

(e) For purposes of this section, a "prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an insured.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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